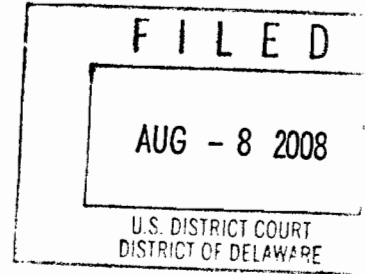


(Rev. 5/05)

**FORM TO BE USED BY A PRISONER IN FILING A COMPLAINT  
UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. §1983**

**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF DELAWARE**



(1) LARRY WARREN # 079644  
(Name of Plaintiff) (Inmate Number)

P.O. Box #9561 WILM, DE 19809  
(Complete Address with zip code)

(2) \_\_\_\_\_  
(Name of Plaintiff) (Inmate Number)

\_\_\_\_\_  
(Complete Address with zip code)

(Each named party must be listed, and all names  
must be printed or typed. Use additional sheets if needed)

vs.

(1) CORRECTIONAL MEDICAL SERVICES  
(2) DEPARTMENT OF CORRECTIONS

(3) \_\_\_\_\_  
(Names of Defendants)

(Each named party must be listed, and all names  
must be printed or typed. Use additional sheets if needed)

\_\_\_\_\_  
(Case Number)  
( to be assigned by U.S. District Court)

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**CIVIL COMPLAINT**

• • Jury Trial Requested

**I. PREVIOUS LAWSUITS**

A. If you have filed any other lawsuits in federal court while a prisoner, please list the caption and case number including year, as well as the name of the judicial officer to whom it was assigned:

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**II. EXHAUSTION OF ADMINISTRATIVE REMEDIES**

In order to proceed in federal court, you must fully exhaust any available administrative remedies as to each ground on which you request action.

- A. Is there a prisoner grievance procedure available at your present institution? ☒ Yes ☐ No
- B. Have you fully exhausted your available administrative remedies regarding each of your present claims? ☒ Yes ☐ No

C. If your answer to "B" is Yes:

1. What steps did you take? I'VE FILED NUMEROUS GRIEVANCES  
I'VE ALSO WENT THROUGH THE APPEAL PROCESS.
2. What was the result? NOTHING WAS DONE AT THE TIME. UNTIL  
I FILED A GRIEVANCE ONTO OF THE OTHER GRIEVANCES

D. If your answer to "B" is No, explain why not: \_\_\_\_\_

**III. DEFENDANTS** (in order listed on the caption)

(1) Name of first defendant: CORRECTIONAL MEDICAL SERVICES

Employed as HEALTH CARE PROVIDERS at HOWARD R. YOUNG CORRECTIONS

Mailing address with zip code: P.O. BOX #9561 WILM, DE 19809 AS WELL AS  
12647 OLIVE BVD. P.O. BOX #419052 ST. LOUIS, MISS. 6314-9052

(2) Name of second defendant: DEPARTMENT OF CORRECTIONS - CARL DANZBERG

Employed as COMMISSIONER at H. R. Y. C. I

Mailing address with zip code: P.O. BOX #9561 WILM, DE 19809 OR  
1301 EAST 12TH ST. 245 MCKEE ROAD DOVER, DE. 19904

(3) Name of third defendant: \_\_\_\_\_

Employed as \_\_\_\_\_ at \_\_\_\_\_

Mailing address with zip code: \_\_\_\_\_

(List any additional defendants, their employment, and addresses with zip codes, on extra sheets if necessary)

**IV. STATEMENT OF CLAIM**

(State as briefly as possible the facts of your case. Describe how each defendant is involved, including dates and places. Do not give any legal arguments or cite any cases or statutes. Attach no more than three extra sheets of paper if necessary.)

1. I'VE HAD (2) STROKES SINCE MY INCARCERATION.  
THE FIRST ONE OCCURED ON JULY 7<sup>TH</sup> 2007 IN WHICH  
I LOST ALL MOBILITY IN MY RIGHT ARM & LEGS. AND  
THE STAFF (C.M.S) HERE AT H.R.Y.C. I DID NOTHING  
TO HELP OR ADDRESS MY NEEDS / SITUATION
2. THE (2) STROKE OCCURED ON NOV. 15, 2007 AND ONCE  
AGAIN I LOST COMPLETE USE / MOBILITY IN MY RIGHT  
ARM & LEGS AGAIN, BUT THIS WAS NOT WORSE THAN  
THE FIRST ONE! AND ONCE AGAIN NOTHING WAS DONE  
BY C.M.S TO PROPERLY TREAT OR ADDRESS MY SITUATION!
3. AFTER MY SECOND STROKE AND NOTHING WAS DONE BY  
C.M.S I STARTED MY GRIEVANCE PROCESS. BECAUSE ON  
TWO DIFFERENT OCCASIONS C.M.S FAILED TO PROVIDE ME WITH  
ANY HELP. EITHER WITH OUTSIDE HOSPITAL VISIT OR TO BE  
SEEN BY A SPECIALIST. BUT DID SEE A PHYSICAL THERAPIST. . .

**V. RELIEF**

(State briefly exactly what you want the Court to do for you. Make no legal arguments. Cite no cases or statutes.)

1. I WOULD LIKE TO RECEIVE PROPER MEDICAL  
TREATMENT HERE FROM C.M.S OR A OUTSIDE DR. /  
DOCTORS!

CONTINUE: . . . . AND MY FIRST SESSION WAS THE NEXT WEEK WHICH WOULD BE 5/21/08. BUT FOR A PERSON THAT JUST HAD (2) STROKES AND WAS IN THE CONDITION I WAS IN, SEEING A PHYSICAL THERAPIST ONE DAY A WEEK FOR 10-15 MINUTES IS NOT ENOUGH TIME FOR ONE TO START THE HEALING PROCESS THAT I MUST GO THROUGH TO REGAIN FULL MOBILITY IN MY ARMS & LEGS, ESPECIALLY SOMEONE THATS MY AGE (61). PLUS I HAVE NOT BEEN TO TREATMENT FOR THE PAST (5) WEEKS BECAUSE THEY ALL HAVE BEEN CANCELED.

DATES CANCELED:

- \* 6/25/08 - "JUNE"
- \* 7/02/08 - "JULY"
- \* 7/9/08 - JULY
- \* 7/16/08 - JULY
- \* 7/24/08 - JULY
- \* 7/30/08 - JULY

2. I WOULD LIKE TO HAVE MY PHYSICAL THERAPY  
SESSIONS TO LAST LONGER THAN SOME 10-15  
MINUTES, FOR ONE DAY A WEEK. SO THAT I  
MAY REGAIN SOME MOBILITIES IN MY ARM + LEGS.
3. AND I WOULD LIKE TO RECEIVE SOME KIND  
OF MONETARY DAMAGES FOR MY PAIN AND  
SUFFERING.

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 31 day of JULY, 2008.

Mr. Larry Warren  
(Signature of Plaintiff 1)

(Signature of Plaintiff 2)

(Signature of Plaintiff 3)

MR. LARRY WARREN  
S.B.I. #079644  
P.O. Box #9561  
WILMINGTON, DE. 19809

CLERK OF COURT  
U.S. DISTRICT COURT  
LOCKBOX #18  
844 N. KING STREET  
WILMINGTON, DE. 19801

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